REFERENCE INFORMATION

REFERENCE A
GLOSSARY

A

Abuse
May be intentional or unintentional; directly or indirectly results in unnecessary or increased costs to the Medicare Program.

Advance Beneficiary Notice
A written notice that a provider or supplier gives to a beneficiary before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare.

Aged Insured
A beneficiary who is at least 65 years old and eligible for Social Security, Railroad Retirement, or equivalent Federal benefits. For Medicare purposes, beneficiaries attain age 65 the day before their actual 65th birthday.

Appeal
An independent review of an initial determination made by a Medicare Contractor.

Assignment
When a provider or supplier is paid the Medicare allowed amount as payment in full for his or her services.

B

Balanced Budget Act of 1997
Law that amended Sections of the Social Security Act to include anti-fraud and abuse provisions, program integrity, and preventive care benefits and established the State Children's Health Insurance Program and the Medicare + Choice Program (now known as Medicare Advantage or Part C of the Medicare Program).

Beneficiary
An individual who has health insurance through the Medicare Program.

Benefits Improvement and Protection Act of 2000
Law that amended Titles XVIII, XIX and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare, Medicaid, and State Children's Health Insurance Programs.

C

Carrier
Contractor for the Centers for Medicare & Medicaid Services that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments (see Medicare Administrative Contractor).

Centers for Medicare & Medicaid Services
An Agency within the U.S. Department of Health and Human Services that administers and oversees the Medicare, Medicaid, and State Children's Health Insurance Programs and awards contracts to Contractors who perform claims processing and related administrative functions.

Certificate of Medical Necessity
Form that is included with claims for certain items that require additional information (e.g., durable medical equipment and parenteral and enteral nutrition).

Claim
A filing from a provider, supplier, or beneficiary that includes a request for Medicare payment and furnishes the Medicare Contractor with sufficient information to determine whether payment of benefits is due and the amount of payment.

Code of Federal Regulations
Official compilation of Federal rules and requirements.

Coinsurance
Percent of the Medicare-approved amount that a beneficiary pays after he or she pays the plan deductible.

Comprehensive Error Rate Testing
Program that measures and improves the quality and accuracy of Medicare claims submission, processing, and payment.

Consultation
Primarily performed at the request of a referring physician or practitioner in order to provide him or her with advice or an opinion.

Coordination of Benefits
The process that determines the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim.

Copayment
In some Medicare health plans, the fixed amount that is paid by the beneficiary for each medical service.

Cost Report
Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service
Reasonable and necessary service furnished to Medicare patients that are reimbursable to the provider, supplier, or beneficiary.

Critical Access Hospital
Hospital that is located in a state that has established a State Medicare Rural Hospital Flexibility Program, is located in a rural area or treated as rural under a special provision that allows hospitals in urban areas to be treated as rural for purposes of becoming a Critical Access Hospital (CAH), provides 24-hour emergency care services using either on-site or on-call staff, provides no more than 25 inpatient beds, has an average length of stay of 96 hours or less and is either more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR certified by the state as of December 31, 2005 as being a “necessary provider” of health care services to residents in the area.

D

Deductible
Amount a beneficiary must pay for health care each calendar year before Medicare begins to pay, either for each benefit period for Part A or each year for Part B.

Department of Health and Human Services
Administers many Federal health and welfare programs for citizens of the U.S. and is the parent agency of the Centers for Medicare & Medicaid Services.

Disabled Insured
Insured beneficiary who is automatically entitled to Medicare Part A after receiving Social Security disability cash benefits for 24 months and is enrolled in Medicare Part B unless he or she refuses Part B coverage.

Durable Medical Equipment
Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

E

End-Stage Renal Disease Insured
Insured beneficiary of any age who in order to maintain life receives regular dialysis treatments or a kidney transplant, has filed an application, and meets one of the following: certain work requirements for Social Security insured status or entitled to monthly Social Security benefits, eligible under Railroad Retirement Programs or entitled to an annuity under the Railroad Retirement Act, or is the spouse or dependent child of an insured individual.

F

Fiscal Intermediary
Contractor for the Centers for Medicare & Medicaid Services that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B (see Medicare Administrative Contractor).

Fraud
Generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal Health care program.

H

Healthcare Common Procedure Coding System
Uniform method for providers and suppliers to report professional services, procedures, and supplies and includes Current Procedural Terminology codes and national alphanumeric codes.

Health Professional Shortage Area
Geographic areas that have been designated as primary medical care health professional shortage areas by the Health Resources and Services Administration.

Hospice
Part A coverage for the terminally ill for the terminally ill beneficiary who meets all the following conditions: eligible for Part A, certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course, receives care from a Medicare-approved hospice program, and signs a statement which states he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions (Medicare will continue to pay for covered benefits that are not related to his or her terminal illness).

I

Incentive Payment
Payments paid to physicians who furnish medical care in geographic areas that have been designated as primary medical care Health Professional Shortage Areas or Physician Scarcity Areas.

Incentive Reward Program
Encourages the reporting of information regarding individuals or entities that commit fraud or abuse that could result in sanctions under any Federal health care program.

Incident To
Services that are commonly furnished in physicians' offices or clinics, furnished by the physician or auxiliary personnel under the direct personal supervision of a physician, commonly furnished without charge or included in the physician's bill, and are an integral, although incidental, part of the physician's professional service.

L

Local Coverage Determination; formerly known as Local Medical Review Policies
In the absence of a National Coverage Determination, a coverage decision made at a local Medicare Contractor's own discretion to provide guidance to the public and the medical community within a specified geographic area; outline coverage criteria, define medical necessity, provide codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity, and provide references upon which a policy is based.

M

Medicaid
A cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources.

Medically Necessary
Services or supplies that are proper and needed for diagnosis or treatment of the patient's medical condition; furnished for the diagnosis, direct care, and treatment of the patient's medical condition; meet standards of good medical practice; and are not mainly for the convenience of the patient, provider, or supplier.

Medical Review
Review of claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems (e.g., errors in billing a specific type of service) are identified.

Medicare Administrative Contractor
As mandated by Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, new single authorities that Fiscal Intermediaries and Carriers will be integrated into beginning in 2006.

Medicare Physician Fee Schedule
Establishes Medicare payment policies and rates for over 10,000 procedures performed by providers, physicians, and certain nonphysician practitioners (e.g., nurse practitioners, physician assistants, and physical therapists).

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Comprehensive bill signed by President George W. Bush on December 8, 2003 to expand many parts of the Medicare Program.

Medicare Summary Notice
Notice that beneficiaries receive on a monthly basis; lists all services or supplies that were billed to Medicare.

Medigap
A health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage.

N

National Correct Coding Initiative
Initiative that promotes correct coding by providers and suppliers and ensures that appropriate payments are made for the services they furnish.

National Coverage Determination
Sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis.

National Provider Identifier
Identifier that all Health Insurance Portability and Accountability Act (HIPAA) covered entities (including Medicare, Medicaid, private health plans, and all health care clearinghouses) must use to identify HIPAA-covered health providers in standard transactions by May 23, 2007. Small health plans must use by May 23, 2008.

Notice of Exclusions from Medicare Benefits
Notice that advises the beneficiary in advance that Medicare will not pay for certain items and services that do not meet the definition of a Medicare benefit or are specifically excluded by law.

O

Office of Inspector General
Protects the integrity of Department of Health and Human Services programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

Overpayment
Funds that a provider, supplier. or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations.

P

Part A of the Medicare Program
Hospital insurance that pays for inpatient hospital stays, inpatient care in a Skilled Nursing Facility following a covered hospital stay, hospice care, and some home health care.

Part B of the Medicare Program
Medical insurance that helps pay for medically necessary services furnished by physicians, home health care, ambulance services, clinical laboratory and diagnostic services, surgical supplies, durable medical equipment and supplies, and services furnished by practitioners with limited licensing.

Part C of the Medicare Program; Medicare Advantage; formerly known as Medicare + Choice
Organizations that contract with the Centers for Medicare & Medicaid Services provide or arrange for the provision of health care services to Medicare beneficiaries who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Part D of the Medicare Program
Prescription drug coverage available to all beneficiaries who elect to enroll in a prescription drug plan beginning on January 1, 2006.

Participating Provider or Supplier
When a provider or supplier participates in the Medicare Program and accepts assignment of benefits for all covered services for all Medicare patients.

Physician (Medicare)
Doctors of medicine and doctors of osteopathy, doctors of dental surgery or dental medicine, chiropractors, doctors of podiatry or surgical chiropody, and doctors of optometry. Must also be legally authorized to practice by a state in which he or she performs this function.

Physician Scarcity Area
U.S. county with a low ratio of primary care or specialty physicians to Medicare beneficiaries.

Practitioner (Medicare)
Any of the following to the extent that he or she is legally authorized to practice by the state and otherwise meets Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, or registered dietician or nutrition professional.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Provider Identification Number; Individual Billing Number
Identifies who furnished the service to the beneficiary on the Medicare claim form, allows providers and beneficiaries to receive payment for claims filed to the Medicare Contractor, required on all claims submitted to the Contractor, and issued by the Contractor.

Q

Quality Improvement Organization; formerly known as Peer Review Organization
Organization that contracts with the Centers for Medicare & Medicaid Services to conduct quality improvement projects, promote the use of publicly-reported performance data, conduct outreach to beneficiaries and health care providers and suppliers, respond to written complaints from Medicare beneficiaries or their representatives about the quality of services for which Medicare payment may be made, monitor payment errors to reduce fraud and abuse, and ensure that patient rights are protected.

R

Remittance Advice
A notice of payments and adjustments that is sent to the provider, supplier, or biller.

Reopening
A remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record; allows the correction of minor errors or omissions without initiating a formal appeal.

S

Skilled Nursing Facility
Facility that meets specific regulatory certification requirements and primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services; does not provide the level of care or treatment available in a hospital.

Social Security Act
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Social Security Administration
Determines eligibility for Medicare benefits and enrolls individuals in Part A and/or B and the Federal Black Lung Benefit Program.

Swing Bed
Beds in small rural hospitals that can be used for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

U

Unique Physician/Practitioner Identification Number; Individual Identification Number
A national number that is used to identify physicians/practitioners who order or refer services; required for consultations, radiology services, and laboratory and diagnostic tests; a permanent number that may be used in any state where physicians/practitioners practice; received by all physicians/practitioners enrolled in the Medicare Program who order or refer beneficiary services even though they may never bill Medicare directly; received by individual physicians/ practitioners (one number is assigned regardless of the number of practice settings); and assigned by the Centers for Medicare & Medicaid Services.

REFERENCE B
ACRONYMS

ABN	Advance Beneficiary Notice
ADA	American Diabetes Association
AEP	Annual Coordinated Election Period
AIC	Amount in Controversy
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
AOR	Appointment of Representative
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BI	Benefit Integrity
CAH	Critical Access Hospital
CC	Chief Complaint
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNS	Certified Nurse Specialist
COB	Coordination of Benefits
CP	Clinical Psychologist
CPI	Consumer Price Index
CPT	Current Procedural Terminology

CRNA	Certified Registered Nurse Anesthetist
CSR	Customer Service Representative
CSW	Clinical Social Worker
CWF	Common Working File
DES	Diethylstilbestrol
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
DRE	Digital Rectal Exam
DSMT	Diabetes Self-Management Training
EDI	Electronic Data Interchange
E/M	Evaluation and Management
EMC	Electronic Media Claims
ESRD	End-Stage Renal Disease
FDA	Food and Drug Administration
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GHP	Group Health Plan
GME	Graduate Medical Education
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIC	Health Insurance Claim

HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPI	History of Present Illness
HPSA	Health Professional Shortage Area
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
ICD	International Classification of Diseases
ICEP	Initial Coverage Election Period
IEP	Initial Enrollment Period
IHS	Indian Health Service
IPPE	Initial Preventive Physical Examination
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LEIE	List of Excluded Individuals/Entities
LGHP	Large Group Health Plan
MA	Medicare Advantage
MAC	Medicare Administrative Contractor Medicare Appeals Council
MIP	Medicare Integrity Program
MLN	Medicare Learning Network
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule

MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination
NEMB	Notice of Exclusion from Medicare Benefits
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Nonphysician Practitioner
OEP	Open Enrollment Period
OIG	Office of Inspector General
OT	Occupational Therapy
PA	Physician Assistant
PEN	Parenteral and Enteral Nutrition
PFFS	Private Fee-for-Service
PFSH	Past, Family, and/or Social History
PIN	Provider Identification Number
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PPV	Pneumococcal Polysaccharide Vaccine
PSA	Physician Scarcity Area Prostate Specific Antigen
PT	Physical Therapist Physical Therapy

QDWI	Qualified Disabled and Working Individual
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
ROS	Review of Systems
RRB	Railroad Retirement Board
RVU	Relative Value Unit
SA	State Agency
SEP	Special Enrollment Period
SHIP	State Health Insurance Program
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
SSN	Social Security Number
TrOOP	True Out-of-Pocket
UMWA	United Mine Workers of America
UPIN	Unique Physician/Practitioner Identification Number
VHA	Veterans Health Administration
VTC	Video Teleconferencing
WC	Workers Compensation
WHO	World Health Organization

REFERENCE C
HELPFUL WEBSITES

Centers for Medicare & Medicaid Services' Websites

Ambulance Services Provider Center
www.cms.hhs.gov/center/ambulance.asp

Anesthesiologists Provider Center
www.cms.hhs.gov/center/anesth.asp

Beneficiary Notices Initiative
www.cms.hhs.gov/BNI

CMS Contact Information Directory
www.cms.hhs.gov/apps/contacts

CMS Forms
www.cms.hhs.gov/cmsforms/cmsforms/list.asp?

CMS Mailing Lists
www.cms.hhs.gov/apps/mailinglists

Comprehensive Error Rate Testing
www.cms.hhs.gov/CERT

Documentation Guidelines for E & M Services
www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Electronic Billing and EDI Transactions
www.cms.hhs.gov/ElectronicBillingEDITrans

HPSA/PSA (Physician Bonuses)
www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Health Insurance Portability and Accountability (HIPAA) General Information
www.cms.hhs.gov/HIPAAGenInfo

Home Health Agency Provider Center
www.cms.hhs.gov/center/hha.asp

Hospice Provider Center
www.cms.hhs.gov/center/hospice.asp

Hospital Provider Center
www.cms.hhs.gov/center/hospital.asp

Internet-Only Manuals
www.cms.hhs.gov/Manuals/IOM/list.asp

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles
National articles designed to inform the physician, provider, and supplier community about the latest changes to the Medicare Program. Articles are prepared in consultation with clinicians, billing experts, and CMS subject matter experts and are tailored in content and language to the specific provider type(s) who are affected by a particular Medicare change.

Medicare
The Official U.S. Government Site for People with Medicare
www.medicare.gov

Medicare Advantage
General Information
www.cms.hhs.gov/MedicareAdvantageGenInfo

Medicare Contracting Reform
www.cms.hhs.gov/MedicareContractingReform

Medicare Coverage Center
www.cms.hhs.gov/center/coverage.asp

Medicare Coverage Database
www.cms.hhs.gov/mcd/search.asp?

Medicare Fee-for-Service Provider Resource Center
www.cms.hhs.gov/center/provider.asp

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo
A planned and coordinated provider education program that offers timely, easy-to-understand materials such as national educational articles, brochures, fact sheets, web-based training courses, and videos.

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate

Medicare Provider-Supplier Enrollment
www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Provider-Supplier Enrollment Contacts
www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp

National Correct Coding Initiatives Edits
www.cms.hhs.gov/NationalCorrectCodInitEd

National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov

National Provider Identifier Standard
www.cms.hhs.gov/NationalProvIdentStand

Open Door Forums
www.cms.hhs.gov/OpenDoorForums

Partner Center
www.cms.hhs.gov/center/partner.asp

Pharmacists Partner Center
www.cms.hhs.gov/center/pharmacist.asp

Physician Fee Schedule
www.cms.hhs.gov/PhysicianFeeSched

Physicians Partner Center
www.cms.hhs.gov/center/physician.asp

Physicians Regulatory Issues Team
www.cms.hhs.gov/PRIT

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Practice Administration Information Resource Center
www.cms.hhs.gov/center/practice.asp

Practicing Physicians Advisory Council
www.cms.hhs.gov/FACA/03_ppac.asp

Prescription Drug Coverage
General Information
www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
www.cms.hhs.gov/PrivateFeeforServicePlans

Public Affairs Center
www.cms.hhs.gov/center/press.asp

Quality Improvement Organizations
www.cms.hhs.gov/QualityImprovementOrgs

Quarterly Provider Updates
www.cms.hhs.gov/QuarterlyProviderUpdates

Regional Office Overview
www.cms.hhs.gov/RegionalOffices

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Resident Training Listserv
www.cms.hhs.gov/apps/mailinglists
Sign up to receive the latest Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program information, including content updates to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*.

State Health Insurance Programs
www.cms.hhs.gov/Partnerships/10_SHIPS.asp

Telehealth
www.cms.hhs.gov/Telehealth

Therapy Services
www.cms.hhs.gov/TherapyServices

Other Organization's Websites

Administration on Aging
www.aoa.gov

Agency for Healthcare Research and Quality
www.ahrq.gov

Commerce Clearing House
www.cch.com

Financial Institutions Examination Council
www.ffiec.gov/default.htm

General Services Administration
Excluded Parties List System
www.epls.gov

Health and Human Services Office of Inspector General
Compliance Guidance
www.oig.hhs.gov/fraud/complianceguidance.html

Health and Human Services Office of Inspector General
List of Excluded Individuals/Entities
www.oig.hhs.gov/fraud/exclusions/listofexcluded.html

Health Resources and Services Administration
www.hrsa.gov

National Technical Information Service
www.ntis.gov/help/subscriptions.asp

National Uniform Billing Committee
www.nubc.org/guide.html

Office of Minority Health
Cultural Competency Continuing Education Programs
http://thinkculturalhealth.org

U.S. Census Bureau
www.Census.gov

U.S. Department of Health and Human Services
www.hhs.gov

U.S. Government Printing Office
Code of Federal Regulations
www.gpoaccess.gov/cfr/index.html

U.S. Government Printing Office
U.S. Government Bookstore
http://bookstore.gpo.gov

REFERENCE D
REFERENCE MATERIALS

Commerce Clearing House Guide to Medicare and Medicaid
Commerce Clearing House, Inc.
www.cch.com
(800) 835-5224

ICD-9-CM Diagnosis Coding Book
American Medical Association
www.amapress.org
(800) 621-8335

Level I CPT Book
American Medical Association
(800) 621-8335
www.amapress.org

Level II HCPCS Book
American Medical Association
www.amapress.org
(800) 621-8335

Medicare Learning Network Publications (providers)
Centers for Medicare & Medicaid Services
www.cms.hhs.gov/MLNGenInfo

Medicare Publications (beneficiaries)
Centers for Medicare & Medicare Services
www.medicare.gov/publications/home.asp
(800) 633-4227

National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers
NTIS Subscriptions Department
5285 Port Royal Road
Springfield, VA 22161
www.ntis.gov/help/subscriptions.asp
(800) 363-2068